TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
OAKBEND MEDICAL CENTER

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-16-0741-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary:

the bill was denied for the codes not being reimbursable for out-patient care. However, as noted on the attached UB04, on 11/17/2014 the charges for OR services, then the patient's surgery occurred on 11/18/2014, he was discharged on 11/19/2014, and the charges on 11/20/2014 are pharmacy charges and observation. Therefore, the patient was in-patient rather than solely out-patient. Our position is the Hospital provided the authorized surgery while relying on the authorization as a representation of payment, and should be reimbursed accordingly.

In the alternative, Liberty Mutual provided the authorization to the Hospital, knowing the specific facility the authorization was being provided to. The authorization was specifically provided to the Hospital, and our records do not show any indication that the facility would be barred from payment because of the facility type.

Amount in Dispute: $201,407.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:

CPT 22842 is Status C per the Outpatient Prospective Payment System. As a Status C code, it is only payable when performed in the inpatient setting. The bill was submitted with type of bill 0131 or outpatient services.

CPT 86900, CPT 86901 and CPT 86850 were paid to afford the facility the allowance that would have applied had these services been billed alone. They were paid at 200% of the CMS rate per TX Fee Schedule.

All remaining charges were denied as Procedure code not reimbursable in an outpatient setting per state or Medicare guidelines. (U415)

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 17, 2014 to November 20, 2014	Outpatient Hospital Services	$201,407.05	$35,040.49

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - U415 – PROCEDURE CODE NOT REIMBURSABLE IN AN OUTPATIENT SETTING PER STATE OR MEDICARE GUIDELINES. (U415)
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.

Issues

1. Are the disputed services inpatient or outpatient hospital services?
2. Did the insurance carrier make a representation of payment based on their preauthorization of the services?
3. Did the insurance carrier preauthorize an alternative facility setting for the disputed services?
4. Did the insurance carrier support denial of payment?
5. What is the applicable rule for determining reimbursement of the disputed services?
6. What is the recommended payment amount for the services in dispute?
7. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code U415 – "PROCEDURE CODE NOT REIMBURSABLE IN AN OUTPATIENT SETTING PER STATE OR MEDICARE GUIDELINES."

   The respondent argues that:

   > CPT 22842 is Status C per the Outpatient Prospective Payment System. As a Status C code, it is only payable when performed in the inpatient setting. The bill was submitted with type of bill 0131 or outpatient services. . . . CPT 86900, CPT 86901 and CPT 86850 were paid to afford the facility the allowance that would have applied had these services been billed alone. . . . All remaining charges were denied as Procedure code not reimbursable in an outpatient setting per state or Medicare guidelines.

   The requestor argues that "the patient was in-patient rather than solely out-patient."

   28 Texas Administrative Code §134.403(d) requires that for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in the rule.

   28 Texas Administrative Code §134.403(b)(3) defines "Medicare payment policy" as reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   According to Medicare payment policies, the hospital indicates the type of bill with a three-digit code in the type of bill field on the hospital bill, box 4 of form UB-04. The first digit indicates the type of facility; a 1 indicates a hospital facility. The second digit indicates whether the services are inpatient or outpatient;

a 1 indicates inpatient services, whereas a 3 indicates outpatient services. The third digit indicates frequency or sequence of claim submission, with a 7 (as billed here) indicating a replacement of a prior claim.

Review of the submitted medical bill finds that the type of bill code submitted on the UB-04 is 137, which indicates outpatient services. The Division therefore finds that the services in dispute are outpatient hospital services subject to the reimbursement provisions of 28 Texas Administrative Code §134.403.

2. The requestor argues that "the Hospital provided the authorized surgery while relying on the authorization as a representation of payment, and should be reimbursed accordingly."

   Per 28 Texas Administrative Code §134.600(a)(8), preauthorization is defined as "a form of prospective utilization review by a payor or a payor's utilization review agent of health care services proposed to be provided to an injured employee."

   Subsection (h) requires that "the insurance carrier shall either approve or issue an adverse determination on each request based solely on the medical necessity of the health care required to treat the injury."

   Although the health care provider may be required to obtain preauthorization for services as specified in the rule, the preauthorization is not a guarantee of payment. It is intended only to address the issue of the medical necessity of the services proposed to be rendered. Review of the preauthorization letter as approved for the services in this dispute finds that the insurance carrier states "we cannot guarantee payment of any bill and treatment requests are reviewed and authorized based on medical necessity only." Accordingly, the requestor has failed to support that the insurance carrier made any representation of payment upon which the health care provider could have reasonably relied. Reimbursement is therefore determined per applicable Division rules and fee guidelines.

3. The requestor argues in the alternative that "Liberty Mutual provided the authorization to the Hospital, knowing the specific facility the authorization was being provided to. The authorization was specifically provided to the Hospital, and our records do not show any indication that the facility would be barred from payment because of the facility type."

   28 Texas Administrative Code §134.403(i) and (j) provide that:

   (i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.
   (j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).
      (1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:
         (A) the reimbursement amount;
         (B) a description of the services to be performed under the agreement;
         (C) any other provisions of the agreement; and
         (D) names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.

   No documentation was provided to support an agreement between the requestor and the insurance carrier to perform the requested services in an alternative facility setting. The requestor's argument that an alternative facility setting had been preauthorized by the insurance carrier is not supported.

4. The insurance carrier's claim adjustment reason code U415 – "PROCEDURE CODE NOT REIMBURSABLE IN AN OUTPATIENT SETTING PER STATE OR MEDICARE GUIDELINES" is supported with regard to those services (procedure codes 20936 and 22842) that have a Status Indicator C, which denotes inpatient procedures not paid under OPPS. The requestor did not meet the requirements as set forth in 28 Texas Administrative Code §§ 134.403(i) and (j) for performing the disputed procedures in an alternative facility setting.

However, not all the disputed services have a Status Indicator of C. The insurance carrier's denial reason is not supported for the disputed services that are eligible for reimbursement in an outpatient facility setting. Those services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

5. This dispute is regarding outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

6. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A payment rate is established for each APC. Hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services (including services billed without procedure codes) is packaged into the payment for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS). Reimbursement for the disputed services is calculated as follows:

   - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415, date of service November 17, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 85025, date of service November 17, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 85610, date of service November 17, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 85730, date of service November 17, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 80053, date of service November 17, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415, date of service November 19, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 85025, date of service November 19, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 86920 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0346, which, per OPPS Addendum A, has a payment rate of $31.57. This amount multiplied by 60% yields an unadjusted labor-related amount of $18.94. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $18.33. The non-labor related portion is 40% of the APC rate or $12.63. The sum of the labor and non-labor related amounts is $30.96 multiplied by 2 units is $61.92. The cost of

these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $61.92. This amount multiplied by 200% yields a MAR of $123.84.

- Procedure code 86900, date of service November 17, 2014, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0345, which, per OPPS Addendum A, has a payment rate of $12.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $7.27. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $7.04. The non-labor related portion is 40% of the APC rate or $4.85. The sum of the labor and non-labor related amounts is $11.89. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $11.89. This amount multiplied by 200% yields a MAR of $23.78.
- Procedure code 86901, date of service November 17, 2014, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0345, which, per OPPS Addendum A, has a payment rate of $12.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $7.27. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $7.04. The non-labor related portion is 40% of the APC rate or $4.85. The sum of the labor and non-labor related amounts is $11.89. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $11.89. This amount multiplied by 200% yields a MAR of $23.78.
- Procedure code 86850, date of service November 17, 2014, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0345, which, per OPPS Addendum A, has a payment rate of $12.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $7.27. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $7.04. The non-labor related portion is 40% of the APC rate or $4.85. The sum of the labor and non-labor related amounts is $11.89. The cost of these services does not exceed the annual fixed-dollar threshold of $2,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $11.89. This amount multiplied by 200% yields a MAR of $23.78.
- Procedure code 38220 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0020, which, per OPPS Addendum A, has a payment rate of $640.91. This amount multiplied by 60% yields an unadjusted labor-related amount of $384.55. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $372.21. The non-labor related portion is 40% of the APC rate or $256.36. The sum of the labor and non-labor related amounts is $628.57. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.225. This ratio multiplied by the billed charge of $25,833.35 yields a cost of $5,812.50. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $314.29 divided by the sum of all APC payments is 4.99%. The sum of all packaged costs is $16,179.73. The allocated portion of packaged costs is $807.01. This amount added to the service cost yields a total cost of $6,619.51. The cost of these services exceeds the annual fixed-dollar threshold of $2,900. The amount by which the cost exceeds 1.75 times the OPPS payment is $6,069.50. 50% of this amount is $3,034.75. The total Medicare facility specific reimbursement amount for this line, including outlier payment and multiple-procedure discount, is $3,349.04. This amount multiplied by 200% yields a MAR of $6,698.08.
- Procedure code 20930, date of service November 17, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 20936, date of service November 17, 2014, has a status indicator of C, which denotes inpatient procedures not paid under OPPS. The requestor did not meet the requirements as set forth in 28 Texas Administrative Code §§ 134.403(i) and (j) for performing this procedure in an alternative facility setting. Reimbursement is not recommended.
- Procedure code 22612, date of service November 17, 2014, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0208, which, per OPPS Addendum A, has a payment rate of $4,003.31. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,401.99. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $2,324.89. The non-labor related portion is 40% of the APC rate or $1,601.32. The sum of the labor and non-labor related amounts is $3,926.21. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.225. This ratio multiplied by the billed charge of $25,833.33 yields a cost of $5,812.50. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,926.21 divided by the sum of all APC payments is 62.31%. The sum of all packaged costs is $16,179.73. The allocated portion of packaged costs is $10,081.42. This amount added to the service cost yields a total cost of $15,893.92. The cost of these services exceeds the annual fixed-dollar threshold of $2,900. The amount by which the cost exceeds 1.75 times the OPPS payment is $9,023.05. 50% of this amount is $4,511.53. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $8,437.74. This amount multiplied by 200% yields a MAR of $16,875.47.
- Procedure code 22842, date of service November 17, 2014, has a status indicator of C, which denotes inpatient procedures not paid under OPPS. The requestor did not meet the requirements as set forth in 28 Texas Administrative Code §§ 134.403(i) and (j) for performing this procedure in an alternative facility setting. Reimbursement is not recommended.
- Procedure code 63030, date of service November 17, 2014, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0208, which, per OPPS Addendum A, has a payment rate of $4,003.31. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,401.99. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of $2,324.89. The non-labor related portion is 40% of the APC rate or $1,601.32. The sum of the labor and non-labor related amounts is $3,926.21. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.225. This ratio multiplied by the billed charge of $25,833.33 yields a cost of $5,812.50. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,963.11 divided by the sum of all APC payments is 31.15%. The sum of all packaged costs is $16,179.73. The allocated portion of packaged costs is $5,040.72. This amount added to the service cost yields a total cost of $10,853.22. The cost of these services exceeds the annual fixed-dollar threshold of $2,900. The amount by which the cost exceeds 1.75 times the OPPS payment is $7,417.78. 50% of this amount is $3,708.89. The total Medicare facility specific reimbursement amount for this line, including outlier payment and multiple-procedure discount, is $5,672.00. This amount multiplied by 200% yields a MAR of $11,344.00.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J2271 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code J0330 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2710 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0131 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1170, date of service November 19, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690, date of service November 19, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405, date of service November 19, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1100, date of service November 19, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1170, date of service November 20, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405, date of service November 20, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 99218, date of service November 19, 2014, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.
- Procedure code 99218, date of service November 20, 2014, has a status indicator of B, which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Reimbursement is not recommended.

7. The total allowable reimbursement for the services in dispute is $35,112.73. This amount less the amount previously paid by the insurance carrier of $72.24 leaves an amount due to the requestor of $35,040.49. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $35,040.49.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $35,040.49 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	December 18, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

	Martha Luévano	December 18, 2015
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.